

DOCUMENT RESUME

ED 452 007

RC 022 944

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TITLE Prevention in Alaska: Issues and Innovations.
PUB DATE 2001-00-00
NOTE 49p.; In: Health Promotion and Substance Abuse Prevention among American Indian and Alaska Native Communities: Issues in Cultural Competence; see RC 022 940.
PUB TYPE Information Analyses (070) -- Reports - Descriptive (141)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Alaska Natives; Alcoholism; *Community Control; Cultural Awareness; *Cultural Relevance; Geographic Isolation; Health Promotion; *Human Services; Mental Health; *Prevention; Program Design; Public Health; *Rural Environment; Substance Abuse
IDENTIFIERS *Alaska

ABSTRACT

Diversity of geography, climate, and culture dictate the nature of the service delivery systems in Alaska, including the provision of prevention programming in substance abuse, alcoholism, health, and behavioral health. Described here are training programs, conferences and symposia, health fairs, and culturally derived interventions that meet the diverse needs of the Native people of Alaska. These interventions operate at the state, local, and regional level with a great deal of attention paid to cooperative and synergistic efforts. Many years of experience with these various programs have led to a body of knowledge that will inform the maintenance of current prevention efforts. Those doing prevention work in the area of health, behavioral health, and alcohol and substance abuse in Alaska should know the context, particularly its rural nature; take time to build relationships and trust; assist community members in finding and developing their own solutions; hire and train local people; design programs around community and family; enable interventions to arise out of Indigenous knowledge and foster choice; introduce Western knowledge in a culturally relevant manner; foster connectivity in training and prevention; and embed prevention efforts within an empowerment paradigm. (Contains 50 references.) (Author/TD)

Prevention in Alaska: Issues and Innovations

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Abstract

Diversity of geography, climate, and culture dictate the nature of the service delivery systems in Alaska, including the provision of drug prevention programming. Described here are training programs, conferences and symposia, health fairs, and culturally derived interventions that meet the diverse needs of the native people of Alaska. These interventions operate at the State, local, and regional level with a great deal of attention paid to cooperative and synergistic efforts. Many years of experience with these various programs have led to a body of knowledge or "learnings" that will inform the maintenance of current prevention activities and the development of future efforts.

As diverse as the land, so are Alaska Native people. Culturally, there are at least four Eskimo language groups (e.g., Yup'ik, Siberian Yup'ik, Cup'ik, and Inupiat); numerous Athabascan linguistic groups with varying dialects (e.g., Gwich'in,

ED 452 007

RC022 944

Koyukuk); the Aleut and Alutiq people; and the southeastern Tlingit, Haida, and Tsimshian groups. Within each region there also exists non-Alaska Native populations including Euro-Americans, Latino Americans, Asian Americans, and African Americans. The percentages vary from area to area but in the numerous small villages the vast majority of residents are Alaska Native.

The geography of Alaska presents logistical and diversity challenges not only for the communities themselves but also for human services delivery. Alaska is a vast area with a population of indigenous and rural people scattered over a geographic area one-third the size of the continental United States. There are approximately 1.07 square miles for each person in Alaska (New York has 0.003 square miles per person). The State encompasses 586,412 square miles and 6,640 miles of coastline and contains four major mountain chains and more than 3,000 rivers (Thompson & Smith, 1991). The rugged terrain, of which about one-quarter is above the Arctic Circle, is buffeted by extreme variations in climate, ranging from average temperatures in January of -14°F in Barrow to 15°F in Anchorage and 34°F in the southeast (e.g., Ketchikan). Daylight hours also vary, the most extreme example being Barrow—which experiences 84 continuous days of sunlight during the summer months and absolutely no sunlight for 64 days during the winter.

Although little more than half of the more than 550,000 people who live in Alaska live in one of the three cities (i.e., Anchorage, Fairbanks, and Juneau), many people live in small, geographically dispersed, rural communities (Thompson & Smith, 1991). The more than 200 villages range in population size from 10 to 700 or more people, interspersed with regional centers of 1,000 to 5,000 people. Transportation in Alaska, due to limited road systems, is largely restricted to airplanes and boats, and snow machines and dog sleds in the winter. Traveling by plane is extremely expensive (it generally costs more to fly in-state than out of the state) and highly unpredictable because of weather fluctuations. Prevention efforts, mental health service, health care, and alcohol and substance abuse treatment delivery become an immense challenge in this environment. Rural areas

can not support health care professionals and mental health providers in each small village. Given the variable weather and distances from cities and regional centers to villages, itinerant professionals are hard pressed to serve the health and mental health needs of such a dispersed rural people.

A focus on diversity, isolation, and the rural nature of Alaska allows one to see the challenges of service delivery. Many Natives call rural villages home. Although nearly one-quarter of Alaska's Native population lives in Anchorage and Fairbanks, the majority are born and raised in villages, have strong ancestral connections to the village and surrounding areas, and carry a fierce pride and loyalty to their home village. Any intervention or planned prevention effort must consider the strengths of these villages and focus on building the community as a whole.

People who leave the village often return periodically or permanently. The village identifies the person. The family name is part of village history. When people introduce themselves through their family lineage, one hears over and over the names of villages joined by marriage and the repetition of the home village's name. As one enters a village, one hears of the pride of place; the accomplishments of the people; the success of the hunt for whale, caribou, or moose; the success of the basketball team; the knowledge of and respect for the elders; and how the village shapes modern life. The taste of traditional foods, the aromas while they cook, and the other smells of the village are missed when a person is gone for even a brief period. People who enter a traditional camp setting for recovery from alcohol abuse comment on how important the traditional foods and rhythm of life are for their recovery. Village life simply moves at a different pace. It is not slow or fast that best describes it; it is a pace built over generations that recognizes the physical and demographic realities of who lives there and what must be done. Waiting and patience are words often used. Perhaps they fit and perhaps they don't. Perhaps the better descriptors are being at peace in the present and preparedness. However one describes the life of a village in rural Alaska, there are unique features that make it that village and no other.

It is the understanding of this unique place and its people that is so critical to prevention efforts. Local control and origination of projects based upon locally articulated needs and strengths are critical to prevention strategies that are empowerment-oriented. What is so crucial is a deep respect for each village as a place where people grow and are nurtured. It is a place where problems exist, but the problems can only be understood and eradicated if the strengths, the positive nature, and the potential of the village and its people are understood and incorporated into prevention efforts.

Communities throughout rural Alaska are creating community-based treatment and prevention methods, as well as using existing indigenous cultural resources to treat and prevent health problems and alcohol and substance abuse (Jennings, Baker, Riggan, & Aubrey, 1993). Further, *People In Peril* (Anchorage Daily News, 1988) described a growing revolution of hope known as the Alaska Federation of Natives (AFN), Inc. Sobriety Movement. The sobriety movement stresses the need for people of the villages, not health agencies and corporations, to take responsibility for their own well-being. Yet alcohol is just one of the health problems Alaska Native people face. Beginning with measures to control and eradicate tuberculosis in Alaska Native villages, which has been a major accomplishment, other health problems, particularly rising concerns about behavioral health risk factors, have received a great deal of current attention because they account for the major causes of mortality. A concern about how to prevent health and behavioral health problems in Alaska has focused increasingly on building personal and community competence in order to increase hope among Alaska Native communities.

Alaska's Need for Preventative Health Programs

What is killing Native residents of Alaska? The answer has changed dramatically over the past 50 years. Before the advent of mass vaccination and widespread availability of antibiotics in

rural Alaska, the leading killer was infectious diseases. In 1950, infectious disease was the leading cause of death, responsible for 45.8 percent of deaths among Alaska Native people (Middaugh et al., 1991). In contrast, the current causes of death among Alaskan Native people are more likely to be related to behavioral health risk factors (Alaska Natives Commission [ANC], 1994). The leading cause of death between 1980 and 1989 was unintentional injuries (22 percent), which included drowning, aircraft and motor vehicle accidents, fires, and injuries related to alcohol and other drug abuse (Middaugh et al., 1991). Heart disease (16 percent), cancer (16 percent), suicide and homicide (11 percent), respiratory problems (6 percent), and congenital diseases (4 percent) followed as the second through seventh leading causes of death. These are variously related to behavioral risk factors including smoking, diet, lack of exercise, stress, alcohol abuse, and drug misuse.

Alcohol abuse is ranked first among behavioral health risk factors in Alaska. In 1994 and more recently, Alaska ranked third among the states in per capita consumption of alcohol (Landen, 1996). According to data from the Behavioral Risk Factor Surveillance System (BRFSS), 22 percent of Alaskans are binge drinkers (Hickle, Lowe, Clarke, Streuber, & Whistler, 1994). Alaska ranks second in binge drinking among the 48 states surveyed in the BRFSS. As many as 45,000 Alaskans are estimated to be problem drinkers.

Up to 25% of all deaths in Alaska are alcohol or drug related; alcohol is involved in one-third of fatal motor vehicle crashes; nearly 50% of child abuse and juvenile crime is related to substance abuse; alcohol has been linked to up to 72% of suicides among Alaska Native males 15–24 years of age—a group with a suicide rate up to 14 times the national rate. (Hickle et al., p. 71)

Further, of the 801 deaths attributable to alcohol between 1992 and 1994, 36 percent were Alaska Natives, although Alaska Native people represent only 17 percent of the State's population (Landen, 1996). In Anchorage, Alaska's largest city, where 5.1 percent of the population are Alaska Native, Native people

accounted for 27 percent of those treated for alcohol abuse, 22 percent of all violent deaths, and 49 percent of all fatal accidents in a 9-month period (*Anchorage Daily News*, 1988).

Alaska's reported rate of fetal alcohol syndrome (FAS) is four times the U.S. average (Hickle et al., 1994). FAS estimates among Alaska Native populations are 5.1 per 1,000 live births compared with 2.2 in North America (Lally, Schubert, Faure, & Parker, 1995). The Alaska Native Public Health Service reported 73 percent of women who had given birth to an FAS child reported being sexually abused as a child. Their data indicate that sexual abuse often occurs simultaneously with alcohol abuse. The ANC (1994) reported alcohol abuse as a significant contributor to the breakdown of family and community life.

Further, suicide rates indicate that on average during the 1980s, a death from suicide of an Alaska Native occurred once every 10 days (ANC, 1994). Research by Hlady and Middaugh (as reported by Kettl & Bixler, 1993) found that 79 percent of Alaska Native suicides (1983-1984) had detectable levels of alcohol in their blood. A review of death certificates and corresponding Indian Health Service records by Kettl and Bixler (1993) indicated that alcohol abuse was diagnosed more often than any other psychiatric disorder for Alaska Natives who had committed suicide between 1980 and 1984.

These statistics demonstrate that alcohol abuse constitutes a public health problem of immense proportions for Alaska Natives. The Alaska Federation of Natives (AFN) report *A Call for Action* (1989) called alcohol abuse "the latest epidemic" to hit Alaska Natives. More recently, the ANC (1994) wrote the following:

As evidenced by both the statistics and the volumes of first-person testimonials given to the Commission by Natives, alcohol abuse among Alaska Natives is a culprit that, if unchecked, holds the very real potential for permanently destroying the social, cultural, physical and emotional well-being of Natives as a people. (p. 69)

Alaska Natives are not alone with respect to alcohol-related problems. Research has shown that Arctic areas generally have

a greater problem than more southern areas, leading researchers to look for genetic causes (Hild, 1987). For example, research with Alaskan and Siberian Natives (Segal, Duffy, Avksentyuk, & Thomasson, 1993) suggested that Alaska Natives eliminate alcohol faster than Euro-Americans and do not possess the atypical genotype found in 50 percent of Asians that serves as a protective factor. Further, historical analyses (Duran & Duran, 1995; Napoleon, 1991; Rose, 1995) point to rapid acculturation and missionary actions as factors in Native alcohol abuse. Generations of Alaskan Native people were removed from their families and sent out to boarding schools, many against their will, which broke down communication between young and old as well as breaking down a sense of Native culture (Charles, 1991; Marum, 1988; Napoleon, 1991; Rose, 1995).

Among infectious diseases, the newest threat to Native lives, as well as all other Alaskans, is HIV/AIDS. Nationally, as of 1995, HIV infection was the leading cause of death for men aged 25-44 and was the third leading cause of death for women in that age group (Centers for Disease Control and Prevention [CDC], 1995). Additionally, while men who have sex with men still make up the largest percentage of AIDS cases, the largest growing segment is due to heterosexual contact. In 1996, 50 percent of AIDS cases in the Nation were men who have sex with men (CDC, 1996), but in Alaska, this risk group made up 57 percent of the total AIDS cases (Alaska Department of Health and Social Services [ADHSS], 1996a). Nationally, 26 percent of AIDS cases are injecting drug users (CDC, 1996), while in Alaska, this group comprises 12 percent of the total number of cases (ADHSS, 1996a).

Between 1982 and 1996, 369 Alaskans were reported to have AIDS (ADHSS, 1997) of which 194 are known to have died, leaving 175 people living with AIDS (PWA) in Alaska. Alaska's 1996 annual rate of AIDS for adult and adolescent males was 11.4 per 100,000, which is below the national average of 51.9 per 100,000 (CDC, 1996). Between 1990 and 1996, an average of 39 new cases of AIDS each year have been diagnosed (ADHSS, 1997). Further, 17 percent of the total number of known AIDS cases in Alaska are in Native American or Alaska Native people

(ADHHS, 1996a). According to testing data, Alaska Natives represented 16 percent of the 590 HIV-positive cases (ADHHS, 1996b). However, these data need to be viewed with caution. Although AIDS is a reportable disease in Alaska, HIV infection without AIDS is not. Consequently, it is more difficult, if not impossible, to get a true measure of the overall HIV infection burden on Alaska's population. Further, determining the infection rates for rural Alaska is even more difficult. People from rural Alaska often come to large urban centers such as Fairbanks and Anchorage to be tested, and are subsequently counted in the numbers for those cities. Additionally, upon diagnosis many people move from the rural setting to urban areas (Bonnie McCorquodale, personal communication, July 1997). Most important, a great number of at-risk people in rural Alaska are not being tested. As a result, there is a real need for HIV/AIDS education, prevention, and screening programs throughout rural Alaska. However, even if testing were readily available in rural Alaska, it is reasonable to expect, considering the amount of social stigma still attached to HIV/AIDS, that it would be used infrequently in such a small, closely tied setting.

As difficult and challenging as the task of prevention may seem given these statistics, it is critical to consider them in the context of the enduring and ancient commitment of Native people to the land and their villages. Because the major killers of Alaska Native people are related to behaviors, there is a great deal that can be done to intervene and reduce further loss of lives. An incredible opportunity to make a difference in the health and vitality of people living in rural Alaska exists. Hearing this call, many organizations from a Federal and State level to individual villages are responding and preventative health programs can be seen throughout Alaska.

Meeting the Challenge

Training for Health Promotion and Prevention

Rural Community Health Aide Program

The challenge of providing ongoing primary health care as well as health promotion in villages was addressed in the 1950s by rural community health aides, which resulted in the creation of Alaska's unique rural Community Health Aide Program (CHAP) in 1987. The goal of the program is to have a trained health provider in each village with a commitment to utilizing local people. CHAP thereby builds the capacity of villages to deal with their primary health care needs. The Community Health Aide (CHA) is educated over a 1- to 2-year period of intense classroom and clinical experiences. The students attend four seminars of variable length taught by faculty who are physician assistants, nurses, or physicians. Once completed, the CHA is supervised and supported by health care professionals in regional centers through telephone consultation and periodic visits. After 1 year of training students receive a certificate, and after completing a 64-credit-hour program, they receive an Associates degree from the University of Alaska (Mohatt & Salzman, 1995). The CHAs are employed by regional Native nonprofit corporations or other tribal contractors. Most if not all Alaskan villages have one or more CHAs who now provide most of the primary health care for rural villages:

The CHAs have become an indispensable, important component of health care for rural Alaska Natives. The CHAs ensure that basic primary care services are available, accessible, continuous, acceptable to the population and cost effective. (Alaska Native Health Board [ANHB], as cited by the ANC, 1994, p. 49)

Rural Human Services Certificate Program

Recognizing the growing need for rural community-based mental health and prevention services, the CHAP model of service delivery and training was adapted to train village-based mental health and prevention para-professionals. The Rural Human Services Certificate Program (RHSCP) offers training to rural human services providers through the College of Rural Alaska at the University of Alaska Fairbanks. The program was developed over a 2-year period through a cooperative effort between the State of Alaska's Office of Mental Health, staff and faculty of the University of Alaska, and a statewide group of Alaska Native people (Mohatt & Salzman, 1995).

The planning group met over a 2-year period to identify what a village-based mental health worker should know in order to work in prevention and service roles in Native communities and how they should be taught. They focused on identifying Alaska Native knowledge bases and Western-based knowledge bases (e.g., counseling approaches with a family and grief focus) that could be adapted in order to be compatible with Native knowledge. The university faculty facilitated the group, structured their work into a curriculum, and had it reviewed a number of times by the statewide council. In 1991, RHSCP became a certificate program at the University. The most central innovation of this program and what makes it unique is that it is an Alaska Native model for education based on integration of Native values and knowledge with Western values and principles that serve to facilitate individual, family, and community healing. The philosophy of the program emphasizes building strengths and wellness of individuals, families, and communities through balance with one's physical, social, and spiritual environments. The philosophy also stresses that effective health service delivery requires healthy and effective providers, thus character development and growth in wellness is integral to the learning of techniques (ANHB, 1994).

Students participate in four 3-week sessions, each week covering a different topic, such as Alaska Native family systems, cross-cultural bridging skills, traditional native counseling,

process of community change, and understanding addictive processes. Students move through the program as a cohort. They meet two times a year, taking different courses each time. Upon returning to the village they complete homework assignments and engage in practice. Faculty for the seminars include elders, practitioners, and university faculty with significant experience in rural settings, and guest speakers with specific areas of expertise.

The students work closely together and form a strong bond and identification with the program and the group. They spend many hours in informal group and individual support and "natural counseling" with each other. Classes integrate content with personal development so that knowledge, personal growth, emotion and intellect, individual and group, catharsis and control, all occur in a supportive, community or family-like, environment. This is fundamentally an interconnected model analogous to kinship. It is one in which relationships between people and between knowledge domains is accentuated. As a result it looks and feels very different from conventional university training. The unique curriculum and approach reflects the expertise of Native people from all levels of the Native community (ANHB, 1994). It is this unique blend that has been characterized by a Yup'ik member of the Rural Human Services Council as "your setting being adapted to our model." Students take back to their villages a process of how people can grow and change through a truly healing community. Personal growth, skills training, cultural revitalization, and community building create the basis for education as a transformative process.

In a recent evaluation of the program (Donahue, 1997) participants revealed that the presence of elders was critical to the impact and the quality of the culturally based curriculum. There is a paucity of literature on how best to work with the elder "wisdom keepers" and RHSCP is undoubtedly breaking new ground in this area. It is clear from the participants that elders become identification models, provide specific advice and emotional support, and assist in articulating how one can approach counseling or other forms of intervention and prevention from a Native perspective. Elders speak of the knowledge of how to

solve and prevent problems and how to understand human problems, and of the ways of treatment that have been used for generations. Wisdom then becomes a living, oral knowledge applied to current contexts.

Further, the RHSCP provides a bridge between the rural workplace and the university system. The RHSCP has developed an entry-level 30-credit curriculum of 100 and 200 level courses leading to a Certificate degree that offers a 2-year Associate of Applied Science degree in Human Service Technology (HST). In turn, the HST degree is offered by the University's School of Social Work. In October 1993, the first training cycle was completed. At this time, there have been 29 Certificate graduates and one Associate's degree graduate and there are more than 50 individuals currently in the program.

In addition to formal training programs such as CHAP and RHSCP, at least two annual statewide conferences, the Prevention Symposium and the Rural Providers Conference, provide opportunities for people working in prevention to gather, share ideas, and learn from a variety of leaders and experts in the field.

The Alaska Council and the Prevention Symposium

The Alaska Council on Prevention of Alcohol and Drug Abuse with the aid of numerous local and statewide sponsors (including the State Division of Alcoholism and Drug Abuse) has hosted an Annual Statewide Alcohol and Drug Abuse Prevention Symposium since 1981. The Symposium is generally held in November in Anchorage and attracts 650-700 participants, 60 percent coming from rural Alaska (Tim McGrath, personal communication, May 1997). Alaska Native people are integral to the planning and success of this conference. A Healing Day Ceremony traditionally kicks off the conference with traditional Native ceremonies, drumming, and dance, encouraging communication among people of diverse backgrounds. In addition, Alaska Native people organize and present many of the conference sessions. Topics in the past have included *Village-based Prevention Strategies*, *What is Community Development*, and *Healing the Wounded Spirit*. The Prevention Symposium attracts

people from all walks of life, including parents, teachers, social workers, prevention specialists, treatment providers, village leaders, and youth. More than 150 youth attend and participate in an activity and presentation tract at the Symposium designed especially for them and for people who work with youth. As an indication of the importance placed on youth involvement, at the 1996 Symposium, a youth provided the first ever youth keynote address.

The Alaska Council, which organizes the annual Prevention Symposium, is a statewide prevention agency dedicated to reducing and eliminating the devastating effects of alcohol, tobacco, inhalants, and other drugs. The Council provides referral services for agencies and has one of the largest specialized, culturally relevant libraries (including books, pamphlets, videos, and school curricula kits) on topics ranging from traditional healing to parenting, substance abuse prevention, healthy choices, self-esteem building, and community building. In addition, the Council has three specialists who travel throughout the State spreading the prevention message, providing specific technical assistance to communities, and keeping current on the pulse of substance abuse in Alaska (Tim McGrath, personal communication, May 1997).

Rural Alaska Community Action Program and the Rural Providers Conference

Since 1965, the Rural Alaska Community Action Program, more commonly known as RurAL CAP, has encouraged efforts of villagers attempting to break the cycle of dependency and gain control of the changes affecting their lives. RurAL CAP works side by side with people in communities throughout the state to develop strategies which will work at the local level and has been involved with the AFN Sobriety Movement since its inception (ANHB, 1994). RurAL CAP is a private, nonprofit corporation whose mission is to protect and improve the quality of life for rural Alaskans through education, training, direct services, advocacy, and strengthening rural people's ability to advocate for themselves. Service and technical assistance programs are directed at child development (such as Head Start and Parent-

Child programs), protection of subsistence and advocacy on behalf of natural resources needed to support a subsistence economy, alcohol and drug abuse prevention, and energy and weatherization projects (RurAL CAP, 1994).

Beginning in the 1970s, in order to address Alaska's need for village-based alcohol and substance abuse services, RurAL CAP sponsored a counselor training program, which eventually evolved into independent programs sponsored by regional health corporations. To assist local efforts, RurAL CAP maintains a statewide network of mutual support through teleconferences, an extensive library and resource center of information and reference materials, and a monthly newsletter. RurAL CAP also provides two manuals, *Nation Building* and *Paths of Discovery*, designed to support the AFN Sobriety Movement. The manuals serve as personal and community empowerment guides for people working in rural Alaska. Additionally, the Alcohol Prevention Program provides specific support and technical assistance through Beginning Alcohol and Addictions Basic Education Studies (BABES) and an FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) Training Specialist. BABES is a primary prevention program that uses puppets to help children develop positive living skills and provide them with information that enables them to make healthy choices about alcohol and other substances (ANHB, 1994).

Since 1984, RurAL CAP has been the driving force behind the annual Rural Providers Conference (RPC). The RPC draws over 300 village-based providers of substance abuse prevention and intervention services around the state, and in recent years the conference has grown to include family members and other participants who come to learn new skills and celebrate their own sobriety. The RPC is planned and facilitated by conference participants, with logistical support from RurAL CAP, co-sponsoring organizations, and the host communities. The conference has been primarily hosted by rural communities, including Soldotna, Nenana, Glen Allen, and Bethel in 1995-96 and Sitka in 1997-98.

Over the years, the conference has grown in both size and sophistication, with well-known speakers and workshops cov-

ering a vast array of technical areas. Yet it still holds firm to its original goal of providing a forum through which rural providers can share information and ideas in a culturally relevant manner (ANHB, 1994, p. 23).

Workshop sessions covering topics such as suicide prevention, inhalant abuse, Native spirituality, and traditional storytelling provide an opportunity for participants to learn about new and traditional approaches to community-based prevention programs to combat alcohol and drug abuse. Evening events such as a potlatch dinner, fiddle dancing, and a cultural sharing night provide opportunities for participants to renew energy and connect with service providers from other parts of Alaska. The conference closes with a Staking Ceremony, a tradition borrowed from the Lakota Sioux and adapted so that participants may honor and symbolize their personal commitment to not back away from the fight against the use and abuse of alcohol (ANHB, 1994).

Statewide Education and Prevention Efforts

AFN Sobriety Movement

The AFN Sobriety Movement is a collective effort on the part of individuals, families, and communities affected by, concerned with, and working toward the prevention of alcohol and drug abuse. It is primarily a campaign whose mission is to encourage and support grass roots efforts to achieve sobriety. Similar to Alkali Lake in northern British Columbia, where community-wide change began with one couple and led to a collective effort and a sober Native community (Guillory, Willie, & Duran, 1988; Johnson & Johnson, 1993), the AFN Sobriety Movement in Alaska began with individuals coming together to help each other. The presentations and the film *The Honour of All* from this community helped to inspire many Alaska Natives to initiate their own community-based process for achieving sobriety (*Anchorage Daily News*, 1988).

The goals of the Movement include encouraging and supporting alcohol-free and drug-free Native families, the practice

of traditional Native values and activities, cooperation with existing groups working to promote sobriety among Alaska's Natives, the formation of sobriety groups in every Alaska Native community, and encouragement and support of sober Alaska Native leaders and role models. One of the activities sponsored by the Movement includes a sobriety pledge drive that helps generate awareness, attract attention to, and encourage participation in sobriety as well as providing a numerical census of who leads, believes in, and supports a sober lifestyle. Each year at the AFN Convention and at other gatherings around the State, members of the Sobriety Movement distribute buttons with the motto "Our Spirit, Strong and Sober" to all those who make a pledge to sobriety. Red ribbons attached to the buttons proclaim "Let it Begin with Me" (ANHB, 1994).

Sobriety Movement members can be seen all around the State, traveling to conferences and gatherings and encouraging people to join the Sobriety Movement and to live the life of sobriety, described as "a positive, healthy and productive way of life, free from the devastating effects of alcohol and drugs" (ANHB, 1994, p. 22).

Another activity is the "Iditapledge for Sobriety" in which pledge signatures are put on microfilm and given to a drug-free Alaska Native dog sled musher, who in ceremonial fashion carries the microfilm in the 1,049-mile Iditarod Dog Sled Race. The race is run annually from Anchorage to Nome in commemoration of the dog team relay that carried vital serum needed to cure the diphtheria epidemic in 1925. Symbolically, the sobriety pledge signatures represent a "serum of commitment" needed to cure the pervasive and devastating effects of alcohol and drugs. In 1994, "musher for sobriety" Mike Williams carried more than 10,000 signatures (ANHB, 1994).

The Movement consists not only of thousands of individuals who have pledged themselves to a life of sobriety, but also more than 50 Charter Groups who have passed resolutions adopting the concepts and goals of the Movement. The movement has been recognized as a model for circumpolar indigenous communities and an effort is currently under way to bring these communities together to share their experiences and knowledge

regarding sobriety efforts (Jim LaBelle, personal communication, May 1977).

The Alaska Health Fair Program

Alaska Health Fair (AHF) is a nonprofit organization whose primary goal is to increase health awareness throughout the State of Alaska and to provide a financially feasible way to deliver primary prevention services to all Alaskan residents (AHF, 1996). The organization provides support and training for communities to plan and stage local health fairs to educate people about various health care concerns through a hands-on approach that includes posters, brochures, multimedia displays, models, screening tests, and counseling. Many of the displays are interactive and fun.

Each year, AHF provides training and technical assistance to community members who want to become health fair coordinators. Coordinator training sessions are held in alternating years in Juneau and Fairbanks or Anchorage and last 2 1/2 days. Training topics range from volunteer coordination and financing to the specific demonstration stations available, choosing a site in the local community, and publicity. The training also includes a demonstration health fair to show participants what health fairs look like and how they run. Trainees are provided with a comprehensive manual (AHF, 1996) that includes AHF history, instructions, ideas, samples, and educational materials such as test values, a glossary of medical terms, and health statistics for the State.

As valuable as the training itself is for the individuals involved, an additional feature of the coordinator training is the chance for participants to meet other people from Alaskan communities with similar interests. A recent coordinator training in Fairbanks included participants from Huslia, Nondalton, Kotzebue, Shishmaref, Savoonga, Bethel, Newtok, and other rural and urban sites, allowing residents of the State to share their ideas about health care promotion in their communities, to brainstorm about future possibilities for prevention-oriented work, and to plan for collaborative efforts.

There is a site fee of \$500 for each fair, which covers administrative costs, materials, forms, equipment, shipping fees, etc. However, AHF tries to keep the cost to the community of the fair at a minimum, so this fee is negotiable and can be reduced or even waived depending on the resources of the community. The fairs are free to people who attend them, with the exception of blood testing, which costs a minimal amount. In 1996, there were 106 health fairs held throughout the State of Alaska, approximately 60 percent of which were in rural communities (Judith Muller, personal communication, July 1997).

AHF is designed in such a way that it gives communities interested in improving their future health status a way to explore and learn with minimal outside involvement. An AHF event is organized, staffed (primarily), and run by local volunteers. Since the community itself is in charge of the health fair and what it contains, it is possible for villages to add and change things that they feel are important in their setting. The sense of ownership and control on the part of the host village or town brings more people into the fair and can provide a real sense of pride and accomplishment upon completion.

Community-Based Suicide Prevention Program

A 1988 study of suicide in Alaska conducted for the Alaska Senate Special Committee on Suicide Prevention documented Alaska's serious problem with high rates of suicide and suicide attempts. Following this study, the State's legislature appropriated funds to begin a new primary prevention program, the Community-Based Suicide Prevention (CBSP) program administered by the Department of Health and Social Services (ANC, 1994; Forbes, 1994). The CBSP program, administered by the State's Rural and Native Services Coordinator Susan Soule, budgets approximately \$850,000 per year for projects designed to build community capacity, target high risk populations, or both. Founded on the principles and practices of community development, the program has empowered a number of villages to implement projects that they have designed locally, based on their own assessment of community strengths, weaknesses, problems, and visions. The projects vary depending on what

best fits a particular context and have included such activities as the direct provision of counseling, teen centers, 24-hour drop-in centers, public community events such as potlucks and performances, afterschool programs, education events and workshops covering a range of topics related to wellness, and elder and youth awareness projects. Projects aim to build self-esteem, cultural pride, respect, family bondedness and wellness, coping skills, and community and individual spirituality. Many of the projects specifically target alcohol, inhalants, and other controlled substances that affect both children and adults.

Starting with 48 projects in 1989, the program has grown to include 60 projects serving 63 communities in 1993. Of the original group of 48 grants, 25 (52 percent) programs are still functioning. There are emerging indications that these projects are in fact resulting in positive change in the communities. A recent evaluation of the program has found that village projects serve as catalysts to advance other important community-based responses to self-destructive behavior.... "As a group, the communities that have implemented their own suicide prevention projects with State funding from this program have shown a 51 percent drop in suicide" (ANC, 1994, p. 46).

Initially, it was planned that project funding would be gradually phased out and the communities would take over support of their projects. However, by fiscal year 1991, the CBSP had shifted to a policy in which the state recognized that each project would need some base level of funding in order to continue (Forbes, 1994). Not only are communities encouraged to develop their own projects and then empowered to implement them with State funding (an approach which is dramatically different from other State-funded behavioral health programs), but the program supports and provides community development specialists who help communities formulate their plans and express them in proposals. This process minimizes the instances of well-intentioned communities failing to receive funds due to technical problems with their proposal (ANC, 1994). In addition, regional groups are brought together at project coordinator conferences in order to share their activities. The monthly *Community-Based Suicide Prevention Program Newsletter* provides

updates on current projects as well as information about upcoming events; funding resources and changes; and descriptions of innovative local, national, and international projects. Given the geographic isolation of villages, the stress on communication and information sharing is critical to success of efforts to build a statewide prevention effort.

HIV/AIDS Education and Prevention

The challenge of providing HIV/AIDS resources to rural Alaska currently is being met at a State administrative level by the Alaska Native Health Board AIDS Project. The Project began in 1988 and was initially funded directly by the CDC. It is now funded partially by State grants and a 5-year subcontract with the National Native American AIDS Prevention Center (NNAAPC). The first 2 years of the project were directed toward understanding rural Alaskans' levels of knowledge about HIV and was followed by an awareness-building campaign using a mass media approach involving posters, videos, and public service announcements. A 1990 Knowledge, Attitudes, and Beliefs Survey indicated that Native communities are aware of AIDS, know what HIV is and how it is transmitted, and know that condoms are an effective barrier in preventing HIV infection (Joseph Cantil, personal communication, July 1997).

In the recent past, the ANHB education and prevention team traveled extensively throughout Alaska to present at health fairs, schools, and community meetings. They often stayed in the villages talking with people, were there as a resource, and answered people's questions. At the request of NNAAPC, the project is no longer responding to requests for local education. The project administrators, along with NNAAPC, realized that such an approach, while providing information to the villages, was not creating an infrastructure within rural Alaska for HIV/AIDS prevention. The AIDS Project is now targeting their efforts at a more administrative level, working on capacity building with the regional health corporations, helping regions realize the need for HIV/AIDS resources at a local level, and working with them to develop their capacity to provide these services to rural Alaskans. The AIDS Project is currently focus-

ing its efforts at training regional providers, showing them how to develop networks and identify resources (Joseph Cantil, personal communication, July 1997).

The AIDS Project staff travel to regional centers to provide intensive training that lasts up to 3 days and draws people from various communities together. This training provides participants with basic knowledge about HIV/AIDS and a framework for addressing it within their communities. The training highlights topics unique to Native communities and rural Alaska and tries to provide a culturally sensitive way of approaching HIV/AIDS (ANHB AIDS Project, 1996). This training is a main part of the ANHB approach to HIV/AIDS education in rural Alaska and is a valuable resource for networking HIV/AIDS educators in rural regions. Additionally, the AIDS prevention team continues to attend meetings such as the Rural Providers Conferences, the annual Bilingual Conference, AFN Youth/Elder Meetings, and the World Eskimo Indian Olympics, where they set up tables and have information, brochures, posters, condoms, and clothing items available.

Regional Prevention and Research Efforts

Maniilaq Health Corporation HIV/AIDS Education Program

At a regional level, individual Native corporations are developing grass-roots approaches more specific to their cultural environments. As an example, Maniilaq Health Corporation (MHC) in Kotzebue, which has a very active HIV/AIDS education program, has found that successful prevention happens when individual villages express a desire to learn and invite their health educator to make a presentation (Barbara Cohea, personal communication, July 1997).

The health educators strive to make presentations as appropriate to the region as possible; thus, the methods are constantly evolving. One approach is to make the presentations feel more like a talking circle by setting chairs in a circle or semicircle. Each session begins with a prayer of thanks to the Creator for bringing the participants together in order to express the under-

standing that nothing happens at random. The programs are highly interactive with the presenter engaging and talking with participants as much as possible. MHC educators use videos that feature Native American actors and videos of testimonials. Listening to personal stories, particularly those of Native American PWAs, is one of the most effective mechanisms for starting conversation and furthering interactive learning. Finally, local MHC educators understand that they are inviting their participants into their home and that the educators are the hosts. As a result, they have learned to provide plenty of food and beverages for participants (Barbara Cohea, personal communication, July 1997).

This type of locally run program has the advantage of being able to respond to the unique situations presented by their region. There are often great difficulties in bridging the gap between urban and rural areas when doing health education (Barbara Cohea, personal communication, July 1997). In rural Alaska, people are sometimes suspicious of people coming in from Anchorage, Juneau, or Fairbanks. Additionally, it is impossible for a person who lives in urban Alaska, or even in rural Alaska, to know how to approach all of the different villages. The villages of Alaska present such diversity that the common "one size fits all" approach does not work. As a result, grass-roots programs work best.

MHC health educators also attend and present at town meetings and schools, staff booths at health fairs, make public service announcements, read articles on the radio, provide posters to villages, advertise in the *Arctic Sounder* newspaper, and loan educational videos to village television stations. MHC recently supported a student from the Alaska Technical Center in Kotzebue who produced an HIV/AIDS brochure from a Native perspective. Additionally, MHC provides continuing education training for Alcoholism Program educators (Barbara Cohea, personal communication, July 1997).

Obviously, there are different approaches to HIV/AIDS education throughout rural Alaska. The one thing that is clear to all educators and providers involved is that increasing awareness that HIV/AIDS is a threat to rural Alaska needs to be a top pri-

ority. With other more visible issues at hand, such as alcoholism and drug abuse, it is easy for villages to overlook the very real threat of HIV/AIDS in their communities. As a result, programs as different as ANHB and Maniilaq each serve necessary functions and can act as models for future endeavors.

Alaska Siberia Medical Research Program:
Diabetes and Coronary Heart Disease Prevention

The Alaska Siberia Medical Research Program (ASMRP) is focused on identifying and preventing diabetes and coronary heart disease (CHD) in Alaska Native people. The project, headed up by Sven Ebbesson at the University of Alaska Fairbanks, was introduced in response to concern among Alaska Native people and researchers about an apparent increase in prevalence of type 2 diabetes mellitus (DM) and CHD within Alaska's various Native groups. Prior to the mid-1980s it was believed that type 2 DM was rare in Alaska Native populations and earlier research showed an estimated prevalence of 1.7 percent among Central Yup'iks (Mouratoff, Carroll & Scott, 1967). The first task performed by ASMRP was a thorough screening of interested Siberian Yup'ik people over the age of 25 on St. Lawrence Island, and in one Central Yup'ik village and one Inupiat village, both of which were on the mainland coast. The screening consisted of a nutrition survey, a personal interview, a physical exam including an electrocardiograph, urine and blood sample collection, and glucose-tolerance tests.

The results of this screening were worrisome to those involved in the project, since they illustrated a trend of increasing type 2 DM prevalence following the modernization of lifestyle, a trend similarly reported in studies of indigenous groups throughout the world (Ali, Tan, Sakinah et al., 1993; Bennett & Knowler, 1979; Knowler, Pettit, Bennet et al., 1983). According to a 1992 screening, the rate of type 2 DM among Siberian Yup'ik villagers was 9.0 percent (Schraer, Ebbeson, Adler et al., 1996). By 1994, this same population had an age-adjusted prevalence rate of type 2 DM of 6.3 percent for men and 12.5 percent for women (Ebbesson, Schraer et al., 1996). Further, in comparison with Siberian Yup'iks of Russia's

Chukotka Peninsula, prevalence rates in Alaska were 10 times higher. The Siberian Yup'ik people of Alaska and Russia provide excellent comparison groups because of their close genetic relationship to one another through common intermarriage prior to the closing of the Iron Curtain. One difference is that the Chukotkan people have maintained a largely traditional lifestyle (Young, Schraer, & Shubnikoff et al., 1992).

ASMRP's intervention program is based on the hypothesis that a major factor contributing to the current rise in the rate of type 2 DM among Alaskan Siberian Yup'iks is their adoption of a Westernized lifestyle consisting of reduced physical activity, increased overall food consumption, and increased saturated fats consumption. The overall aim of the intervention program is to advocate movement back to a more traditional way of life. Dietary considerations vary between villages and cultures, but desired changes include eating more traditional foods such as seal, whale, walrus, reindeer, sea greens, and marine mammal oils as well as substituting healthier Western alternatives for cooking, such as canola or olive oil instead of lard and vegetable shortening. It also involves reducing consumption of unhealthy foods such as soda, fried foods, bacon, refined sugar, coffee, potato chips, cookies, and fatty meats. In order to facilitate the desired dietary changes, project staff meet regularly with village store owners to advise them about which foods to stock. In addition, the project works with the company that supplies the village stores to increase the availability of foods that ASMRP feels are needed in the villages. Since the beginning of the intervention, project staff have seen a dramatic change in the availability of healthy alternatives, and the owners report that many of the new items sell very well. The physical activity portion of the intervention aims to reduce villagers' sedentary lifestyle changes by developing knowledge of the importance of minimal exercise and by providing organized means of increasing activity.

The project identified members of four Yup'ik and Inupiat villages around Alaska's Norton Sound region who either currently have or are at increased risk of developing type 2 DM, CHD, or both. With this population, ASMRP goals are to

develop, implement, and compare two culturally sensitive interventions within the villages and to evaluate their success with a final screening of all active participants. Two villages receive community-based intervention strategies, while the other two villages receive individual-oriented strategies. In developing the content of these strategies, ASMRP team members met with village health councils, government officials, and residents to brainstorm about possible effective mechanisms of intervention and to find out what people in the villages would like to see done.

The community-based intervention consists of mailings and letters sent to all participants that provide information that is deemed helpful and essential by the research team. It also includes town meetings, presentations, and exposure to materials through the local health clinics. Finally, it utilizes local media services such as village television stations and radio broadcasts. The regular mailings include letters that keep participants apprised of what is happening with the program and what has been found regarding the health status of their communities. The letters also encourage participants to return to healthier, more traditional ways of life. Included are lists of foods to eat and foods to avoid, as well as suggestions of ways to increase their level of activity.

The individual-oriented approach consists of visits to each home by members of the ASMRP research team to interview and talk with each participant about the health concerns for their village, the dietary changes that are advised, and the need for increased physical activity. The interview is structured and includes questions about the person's amount of walking; whether they are trying to lose weight; and a nutrition inventory that includes a list of foods and asks if the person ate the item in the last week, how many times they ate it, and for how many years they have eaten it. Throughout the interview, this inventory is used as a tool to introduce ideas about healthier eating habits.

The second phase of the prevention program involves hiring and training of a full-time intervention worker in each of the villages. This local individual will run the programs for their village and, along with ASMRP staff, will deliver the new inter-

vention methods. It is believed that the only way to achieve a successful and lasting change in risk behaviors is if the push for change comes from someone who is a member of the community. On the advice of village residents, a strong emphasis on dance as a form of physical activity will be expressed. An aerobics video that includes two young Native women as the dancers and one Caucasian instructor has been made for use in the villages. Also, exercise bikes will be made available in each of the villages. The bikes were chosen for their ease of use and sturdiness and because they allow the user to work at a comfortable pace. Classes in dietary choices, dance, and cooking will be added, as will organized Native dances and interactive health discussions.

The Road Back: A Village-Based Prevention Strategy¹

The Council of Athabascan Tribal Governments (CATG) was formed in 1985 as a response by the Chiefs of the Yukon Flats region to unify their voices against the threat of opening the Arctic National Wildlife Refuge to oil exploration, thereby invading the Porcupine Caribou herd's calving grounds and threatening the existence of the herd and the subsistence lifestyle of the people. Since this time, the CATG has begun a process of increasing the quality of life in all 10 villages of the upper Yukon Flats by taking on projects that employ and empower local Athabascan people.

CATG villages are located in the Yukon River Valley between the Brooks Range and the White Mountains from the Canadian border to below the Dalton highway where the village of Rampart marks the farthest village down the Yukon River in the consortium. The villages that comprise the CATG are Arctic Village, Beaver, Birch Creek, Canyon Village, Chalkyitsik, Circle, Fort Yukon, Rampart, Stevens Village, and Venetie. The dominant culture of the area is Athabascan, including the Gwich'in and Koyukon dialects. The Council of Athabascan Tribal Governments has long been aware of the social issues that exist in the communities and takes into consideration the history of Alaska Natives as one of the greatest causes of substance abuse. The process of healing therefore includes taking into considera-

tion the economic, educational, political, and social histories. Prevention programs need to be flexible in order to address the issues most relevant to the villages on an individual basis.

A Center for Substance Abuse Prevention (CSAP) Community Prevention Coalition Demonstration grant was awarded to the CATG, and The Road Back: A Village-Based Prevention Strategy was implemented. This 5-year demonstration project has three goals. The first is to form a community alcohol and drug abuse prevention coalition at regional and local levels in the Gwich'in Athabaskan villages of the upper Yukon drainage. The coalition consists of existing and new partnerships and involves the expansion of long-range, comprehensive, multidisciplinary, community-wide, and regional substance abuse prevention programming. The second is to further develop and enhance culturally competent preventive education and training programs in the proposed partnership area. The third goal is to expand and enhance culturally competent substance abuse prevention programming across an expanded geographical area through partnership development and local prevention linkages.

Each of the village's Tribal Councils acts as the direct supervisor of the Prevention Workers and provides the direction of the prevention programs. Some of the villages use the coalition-building process as the priority of the prevention program, while others concentrate more on prevention in the school or on using and enhancing cultural practices and knowledge. In all cases, the village prevention program is seen as one whose ownership is based at the village level, as a part of community development. For example, in Arctic Village, Prevention Worker Kenneth Frank coordinated three age groups of students on three camping trips to climb the surrounding mountains. The mountains around the village are 2,500, 3,000, and 6,000 feet high. Some of the students had lived in the village all of their lives but none had climbed the mountains before these outings. Once on the mountain peaks, the youth ate and discussed their sense of accomplishment and pride in overcoming their fear and reaching their goal. Prevention Workers in Rampart (Margaret Moses), Stevens Village, and Venetie have sponsored similar

prevention activities involving camping, moose hunting, and trips involving subsistence activities.

In Beaver, Prevention Worker Francine Henry collaborated with the Beaver Tribal Council to facilitate the 4th of July festivities. Ms. Henry has an active youth group that is made up of youth who meet to have a sewing group; she has also had slumber parties to discuss substance abuse issues. The Prevention Worker in Arctic Village (Mr. Frank) started two sweat lodge groups, a women's and a men's group that include both youth and older adults. In the sweat lodge, traditional customs are practiced and sobriety dates are celebrated.

In Chalkyitsik, Prevention Worker Minnie Salmon collaborated with the village Tribal Council and Indian Child Welfare Act Worker to facilitate a camp up the Black River with 15 students. The majority of the time was spent on cultural activities at the camp. A caribou hide boat and dog pack were made along with lessons on how to knit a fish net. The fish net was not completed at the end of the week-long camp but plans were made to finish it with the youth over the winter. In addition to the cultural activities, lessons on drug and alcohol addiction were provided. The camp ended with two of the oldest students, both young women, paddling the skin boat down river to the village. When they arrived the village residents and everyone from the camp were waiting on the bank to greet them: one of the many historic moments created by the CATG/CSAP prevention project. Cultural camps were also held by the Prevention Workers in Canyon Village (Delma Fields) and Venetie.

In Circle, Prevention Worker Margaret Henry John has collaborated with the village Tribal Council to open a community center. The youth have a pool table and organized games with prizes. There is an outdoor volleyball net for all that want to play and participate. The Fort Yukon Prevention Worker, Kimberly Carlo, initiated a traditional Native dance group for teenage youth, which performed at the annual Festival of Native Arts in Fairbanks, and the Quyanna night during the AFN's annual convention in Anchorage. The Quyanna night event was broadcast over the rural communication system and viewed in more than 200 villages. Richard James, the Prevention

Worker in Birch Creek, combined resources with the school district to also sponsor a youth Native dance group at the Festival of Native Arts.

Stevens Village youth, with the leadership of Prevention Worker Cheryl Mayo-Kriska and in collaboration with the school and village Tribal Council, toured one of the Trans-Alaska Pipeline's pump stations and a local fish camp and museum. Prevention Worker Judy Erick (Venetie) said, "as a result of camping and spending quality time with each child, the kids I work with are closer to me, have trust in me, and are not afraid to talk to me about anything."

All Prevention Workers are employed directly by the Council of Athabascan Tribal Governments, which administers the grant. Also employed by the grant is a Counselor/Supervisor, Floris Johnson, and a Project Director/Evaluation Coordinator, Charleen Fisher. The Counselor/Supervisor provides technical support and acts as a resource for the Prevention Workers and communities. In addition to basic project administration, the Project Director works with the Counselor/Supervisor and the Prevention Workers on report and evaluation activities that keep the project in compliance with grant requirements. All the employees of The Road Back: A Village-Based Prevention Strategy are Alaska Native People from the villages in which they work.

The Road Back: A Village-Based Prevention Strategy has a program design that fits the new paradigm, an empowerment approach to prevention programs. It therefore was essential that evaluation of the program also fit this paradigm. The following were recommended steps for evaluating the prevention program, as developed by the CATG staff and consultant Dr. Alicia Martinez. The process for evaluating the success of The Road Back: A Village-Based Prevention Strategy begins with each community's Prevention Worker. This is part of the program's effort for self-determination. The evaluation involves the following steps:

- Step 1: The Prevention Worker and community collaborate to carefully specify the target group.

- Step 2: The Prevention Worker presents two alternative proposals related to drug and alcohol abuse to the community for discussion and selection.
- Step 3: A representative group of participants is selected to be interviewed.
- Step 4: The Prevention Worker conducts and documents the prevention activity.
- Step 5: The Prevention Worker conducts interviews with selected participants on effects of the activity soon after the activity is held.
- Step 6: A followup interview with the target group participants is scheduled and conducted at a later date, if possible.
- Step 7: Interviews are transcribed and reviewed for essential common patterns.
- Step 8: Reports are written, making sure that the information presented is valuable to the community.

The results of this process are then made into a booklet and distributed to the villages as a way to celebrate healthy activities. The prevention effort by the CATG is an innovative approach to prevention. While most substance abuse prevention efforts consist of only two activities, and slightly less than 25 percent of the programs supported by CSAP consist of three or more activities, the CATG prevention program has the potential for 10 activities to be developed and conducted at any one time, therefore making it a unique program. The CATG prevention program illustrates how Alaska Native people are working to determine their own destiny and providing important information for future substance abuse prevention efforts.

Spirit Camps

A tradition exists within Alaska Native communities of summer fish camps to harvest and prepare fish for the family (Kawagley, 1995). Fish camps involve an extended family process in which generations come together to work and share the responsibility of catching, cutting, drying, smoking, and packaging for storage hundreds of fish (primarily salmon), ensuring that the family

has adequate food for the winter. In addition to harvesting fish, camp members may harvest berries and use the camps as hunting camps during various times in the year. During the early part of the 1980s, the Northwest Arctic Natives Association (NANA) began a process of inviting elders to meet in order to articulate the central values associated with being an Inupiat. The NANA spirit movement was born from this process along with a commitment to transmit these values to young people in order to ensure the survival of Inupiat culture and to prevent anomie and alienation as well as substance abuse and suicide. Cultural camps, modeled on the summer fish camps, were designed to reintegrate young people into community subsistence activities and to expose young people to the teaching of values by elders. These camps were almost entirely focused on youth and adolescents rather than on young and middle-aged adults. The feeling of NANA leaders was that they needed to focus on the health of the youth in order to ensure strength for the future.

During the same time, Donald Peter, Director of the University of Alaska Fairbanks Alaska Native Human Resource Development Program, initiated a similar process with tribal elders (primarily but not entirely from Athabascan tribal groups) through the Respiritualization Task Force (Hampton, Hampton, Kinunwa, & Kinunwa, 1995). They generated the idea of sponsoring spirit camps as a place where tribal elders could transmit their knowledge and values both through talking to participants and through the rhythm and the activities of the camp. The camp would be a healing place (Katz & Craig, 1987). Camps vary in type: some are youth-oriented, some are family-focused, and some are engaged in alcohol detoxification and recovery. The idea of spirit camps has been embraced by tribal groups throughout Alaska and is frequently being used for alcohol treatment. Two of the most well known camps are the Ga'alleya Spirit Camp of elder Howard Luke and the Old Minto Cultural Heritage Camp led by Robert Charlie and elders from Minto. Also located at the Old Minto village site is a recovery camp that is operated by the interior tribal corporation, Tanana Chiefs Conference.

The typical framework for spirit camps such as Ga'alleya is for participants to come for a 1-week stay. They camp in tents or live in log houses and work with tribal elders on a variety of projects such as wood gathering, building structures, processing fish and berries, and other traditional fish camp activities. During the day and in the evening, the group gathers for talking circles. These circles have been modeled on American Indian ceremonial structures such as healing ceremonies and purification rites, in which individuals sit in a circle and each person speaks without interruption. Talking circles typically demand that individuals remain in the group until the circle is finished. A sacred object such as an eagle feather is passed from person to person, which they hold while they speak. No topic is forced on the speaker. They speak and participants respectfully listen. During these periods, participants may tell personal stories of their struggles and growth. Elders may share their personal stories or particular cultural stories that belong to them or to their group. Howard Luke often speaks to the participants early on about *Alleya* (luck) and the weasel that would come to visit the people's homes. The weasel would knock on the door, look into the home, and examine it to see if the residents live in harmony and respect. Was it a clean home? Were the animals who were hunted prepared in a respectful way? Did the people speak to each other with respect and love each other, especially the children? If the weasel saw a respectful house, *Alleya* would enter and stay with them. Such stories dramatically teach the participants about deep cultural meanings concerning how one should live. They both inspire and teach. In the Old Minto camp, such events frequently happen. Elders speak strongly about cultural values and about rules for conducting oneself within the family and community.

In the NANA region, camps were used to bring people who sought help with health and other problems into interaction with traditional Alaska Native healers. Camps in that region were often held at traditional hot springs and allowed individuals to be doctored by the healers. Although no longitudinal study is available concerning the effectiveness of spirit camps for alcohol recovery, case studies have discussed the conceptual

model and how strongly it resonates with Alaska Native values and aspirations (Hampton et al., 1995; Hughes, 1997).

Spirit camps provide a foundation for community development. An individual community member could have a substantial effect on community healing by working with others to identify traditional sources of strength and implement projects based on these traditions.... These models are valuable not only because they connect us with the traditions of the people and our true selves but also because nature is a sacred and healing place that helps us to be wise and creative as we work towards our future. (Hampton et al., 1995, p. 263)

Policies to Control Access to Alcohol

Prior to the purchase of Alaska, alcohol had been a commodity for trade between the Russians and the Native people of Alaska (Anderson, 1988). After the purchase of Alaska by the United States, Alaska Natives lived with prohibition until 1953. After 1953, alcohol availability did not change appreciably until 1962. Historically the relationship of the United States to alcohol use by Alaska Natives has been the exercise of external power:

The assumption of Native inability to exercise self-control over the use of alcohol originated with contact. Teachers and missionaries saw suppression of drinking as the prerequisite for civilizing the Natives; they actively advocated law enforcement efforts to protect Natives from whites and to protect them from themselves.... The majority of the alcohol control legislation since that time has originated externally to local communities and has had Natives as its specified or unspecified target.... Thus, before the turn of the century, non-local controls, widespread organized violation, race-selective enforcement, and local Native enforcement personnel were all present as, to some extent, they remain today." (Lonner & Duff, 1983, p. 11, 2-3)

Historically, alcohol use was strictly controlled by elders, chiefs, and councils and by the remoteness of villages. This resulted in a lack of access and the absence of alcohol-related social prob-

lems. In many villages, a history of making home brew existed and its availability was patterned for use during celebrations. Informal and formal controls at the community level prevented widespread behavioral violations of an interpersonal nature. It appears that after 1962 alcohol abuse increased as the cash economy grew and families were split by boarding school, work, and other forms of out-migration and increased contact. Still, local formal and informal controls existed and were enforced. Studies suggest (Lee, 1994; Lonner & Duff, 1983) that the more traditional the village, the stronger the controls and the fewer the alcohol-related problems. In the mid-seventies, there was a serious effort on the part of state and local leaders in the Native and non-Native community to develop new legal forms to control alcohol use through a local form of prohibition.

In 1981, the Alaska Local Option Law (ALOW) was passed by the legislature, with additional options amended in 1988 (Alaska Department of Community and Regional Affairs, 1995). It is applicable to any community in the State, but has only been used by communities that are predominantly Alaska Native. The law allows a community to vote on whether to restrict the sale, possession, or importation of alcoholic beverages into a community. Violations are either misdemeanors or felonies and a variety of sanctions exist, including jail and fines.

Local option has become widespread in regional centers and villages throughout rural Alaska. A recent study (Berman & Hull, 1997) reported that 37 percent of rural communities have approved restrictions under ALOW. Of the 92 communities that have banned alcohol, 11 percent banned the sale only, 59 percent banned both the sale and importation, and 30 percent banned the sale, importation, and possession of alcohol. None of the largest, road-connected communities have approved local option controls. Berman and Hull (1997) further reported that "from 1981 through 1994, 99 communities held 148 local option elections that either added or removed restrictions on alcohol... relatively few communities have tried and failed to exercise some control under the local option law" (p. 2).

The authors further estimated that approximately 52 percent of the Alaska Native population, compared with 11 percent of

Alaska's total population, live in places that restrict the availability of alcohol. The effectiveness of such control in the reduction of either alcoholism or the social problems associated with alcohol abuse has not been adequately documented.

It has become clear over the years that although the local option law has had a positive effect in some villages, in others the impact has been minimal, due either to a vacillating vote or to the continuing problem of bootlegging. (ANC, 1994, p. 44)

Lonner and Duff (1983) indicated great variations in the effect of the law based on how strongly the community accepted and supported it, how well they supported the local village public safety officer, and how strong and intact the village was at an informal control level. They report the experience of many Native people, which points to the importance of a village suddenly becoming dry. People spoke of how the parties stopped, how they were no longer afraid, and how they had more time for their children and subsistence activities. Certainly, people began to find ways to drink by leaving the village or sneaking in alcohol, but Lonner and Duff indicated that the stronger the local controls were, the less abuse and the fewer social problems occurred. Further, recent research reported by the State's Section of Epidemiology (Propst & Landen, 1996) found less restrictive alcohol laws were associated with higher alcohol-related injury deaths and concluded that measures limiting access to alcoholic beverages in rural villages may decrease alcohol-related injury deaths.

The local option also has a powerful symbolic value. It communicates to the people that they have control, that they have and can exercise community standards for behavior, and that they can demand their enforcement. The result has been a growth in sense of community responsibility and "control over community" (Lonner & Duff, 1983, p. XII-26). The ANC (1994) emphasized the importance of empowerment through self-reliance and self-governance in order for communities to reestablish a functional social order:

Alaska Natives are residents of the nation and the state, but they also occupy their own cultural and political communities. Native villages and their tribal governments—as distinct partners with the state and federal governments—must be entrusted with the social and political decisions critical to Alaska Natives future well-being and survival. The validity of Alaska Native cultural perspectives...must be recognized and afforded due respect.... If significant improvements are to be made with respect to overall Alaska Native well-being, the native community must take ownership of the problems and assume responsibility for the solutions....

Any future attempts to regulate alcohol importation and use in Alaska Native villages—as well as the enforcement, prosecutorial, and sentencing powers and resources without which such regulation is meaningless—must be premised on the fundamental belief that Alaska Natives can and should have ultimate and unquestioned control...a continuation of historic and present approaches to the issue should be deemed unacceptable by those who genuinely care about the future well-being of Alaska Natives. (pp. 60, 64, 77)

Conclusion

We have been able to provide an overview of only a smattering of the numerous projects and interventions that have been designed and carried out by Alaska Native people and their communities. For those who wish further information, the ANHB (1994) provides an excellent resource manual that includes many other examples of both individual and community prevention activities as well as how-to's and resource listings. We also refer you to prevention projects documented by McDiarmid (1983) and Marum (1988) and the discussion by Hild (1987).

In light of the high rates of alcoholism and other negative social and health indicators, the reader may wonder whether the interventions we have described are effective. First, it is clear

from epidemiology reports that social indicators have not gone from bad to worse in all cases. In problem areas where target intervention programs have been at work long enough to see summative changes, we do see indications of progress in harm reduction, e.g., in accidents and drowning. In regard to suicide prevention, evaluations of the small demonstration grants indicate progress in those villages that have focused their efforts on prevention. Further, the early data from diabetes prevention programs indicate that rapid increase of diabetes is not occurring in villages, as would be expected without the intervention. These results suggest that targeted prevention efforts that build upon local knowledge and strengths are making a difference.

Yet there are other areas of significance in which it appears that little is changing (e.g., alcoholism, domestic violence, and HIV/AIDS). Although there has been a long history of intervention in alcohol abuse, it is only in recent times that interventions have integrated indigenous knowledge in the planning and operation of preventive and treatment-oriented interventions. Most prevention models and strategies have historically been imported from outside of Alaska and based upon Western paradigms. Planners need not conceptualize the process of building new indigenous interventions to mean that Western methods have no applicability. Our sense is that this polarizes the planning and intervention process and ignores the key question of what will work best for a particular problem and context. An integrated approach or parallel structured interventions in which Native and Western approaches work together may work best. Currently, new models are being considered that come out of Alaska Native paradigms. To develop such interventions, one must clearly articulate the paradigm. This is neither simple nor easy. It is time-consuming, both in determining the local knowledge applicable to a particular problem and in determining how best to apply that knowledge. In the real world of practice, this process often occurs in a context of limited resources, a demand for immediate action, and application prior to clear articulation and planning. Such a process results in significant time spent in trial-and-error learning, and therefore one should not expect immediate summative results.

Consequently, formative evaluation makes the most sense at this time, and only at later stages can one make a case for seeing significant changes at a summative level. We have seen that such formative evaluations point to significant ways in which communities are improving their situation (for example, see McDiarmid's 1983 analysis of the Chevak Village Youth Organization). The need for formative evaluation is particularly important in many problem areas such as HIV/AIDS that are only beginning to be addressed in Alaskan villages. Interventions in these areas need to be monitored carefully in order to understand and take into account the ways in which complex health and social problems are interrelated.

In reviewing the diverse prevention and health education efforts, we have drawn a number of inferences that are critical features of work in rural Alaska. They are summarized here as recommendations and considerations for anyone doing prevention work in the area of health, behavioral health, and alcohol and substance abuse prevention in Alaska, and they are based on what we consider the essential features of those promising practices which have been recently developed.

Know the Context, Particularly Its Rural Nature

Alaska and especially rural Alaska is a complex and diverse setting. Rural means different things in different parts of the United States. If Freud thought biology was destiny, in rural Alaska perhaps geography and culture are destiny. Distance, weather, and the pace of life demand significant patience, a willingness to slow down and wait, and flexibility from prevention workers.

The diversity of Alaskan weather and topography is matched by the diversity of its people's culture and language. Those working in the area of rural prevention must learn the specific cultural ways of the groups with whom they work. Pan-Native, "one size fits all" conceptualizations should be avoided. They hide the real nature of Alaska Native cultural diversity. Additionally, solutions coming from a traditional framework must originate from local knowledge. The process of prevention

should develop local knowledge and wisdom rather than depend on generalized ideas and stereotypes.

Local, Face-to-Face Communities Present Special Dilemmas and Challenges to One's Paradigms and Approaches

Alaska Native villages are face-to-face, kinship, relational-based communities. Everyone relates through kinship. Everyone has long memories and significant experience with each other. This serves both to facilitate and to hamper change. For the person working to prevent and treat alcohol and drug abuse, it means that they must know the community and take the time to build relationships and trust. People and communities are the authors of their lives, and the community-based helper must orient themselves to work *with* the community. The prevention worker should assist community members in finding and developing their own ability to choose and compose solutions to their problems, not do the choosing and composing for them.

Rodenhauser (1994), in reviewing cultural barriers to health care delivery in Alaska, also emphasized the need for service providers to refrain from imposing their values and cultures on the communities, to respect and practice local communication styles, to become part of the village culture and work together with Native healers, to incorporate a local understanding of the problem and its solution, and to assist with restorative efforts at the community level.

Prevention programs should hire and train local people familiar with the setting. Consistent with the emphasis of the ANC (1994), developing local capabilities is essential:

Solutions to the health problems of Alaska Natives lie, then, not simply in health care but more generally in empowerment and involvement of Alaska Native communities in the design, implementation and control of their own programs...that will enable them to regain control of their collective futures. Only by means of re-establishing community control and empowering local decision making can the responsibility for ensuring healthy lifestyles be regained by the community; only through

this process can the individual and the family be reached in any meaningful way that will turn the tide of deteriorating health status among Alaska Native people. (p. 42)

However, when this is done agencies must realize that local people carry with them the history of their family name and personal acts, so programs must consider this in both training and supervision. They must help local workers learn how to work in their own communities without becoming trapped by who they are thought to be because of their own family or personal history. They will need assistance in learning how to negotiate complex new relationships as a helper, which includes how to maintain confidentiality and build trust, how to maintain their role as a natural helper, and how to work within kinship relationships.

Trauma Is Communal, So Interventions Must be Communal

Within Native communities the trauma experienced is fundamentally communal and often historical. Alaska Native communities have suffered a great deal of trauma. Some of it is from epidemics; other traumas are from deculturational stressors such as formal schooling, boarding schools, religions, and economic oppression.

The Commission has determined that many of the causes for today's upheaval in Alaska Native communities and within families can be found in their often tragic experiences since contact with Europeans, and in the cultural, social, political and economic climate created for them by both federal and state governments. At the core of the problems are unhealed psychological and spiritual wounds and unresolved grief brought on by a centuries-long history of deaths by epidemics, and cultural and political deprivation at others' hands. Some of the more tragic consequences include the erosion of Native languages "in which are couched the full cultural and spiritual understanding" and the shattering of cultural value systems. (ANC, 1994, p. 57)

Harold Napoleon (1991), a Yup'ik man from Hooper Bay, has argued that this weakening of Native cultural traditions and values and the trauma associated with acculturation practices of Western institutions are the primary causes of alcohol problems among Alaska Natives. "Through my own studies...and by listening to elders, I have come to the conclusion that the primary cause of alcoholism is not physical but spiritual" (p. 2).

Each village has its own history of trauma. However, any trauma, whether it has historical dimensions or is an individual trauma, affects the community as a whole. When an elder dies, a suicide happens, an accident kills, the whole community is affected, and other communities in the region also feel the impact. Grief and loss are contagious. To heal, one must look beyond the individual to the community and family as a whole. "The emphasis in all substance abuse prevention and treatment efforts must be the community, and within the community, the family" (ANC, 1994, p. 44). Interventions described in this chapter point to ways in which rural villages and Native communities have developed community and family-based interventions.

Interventions Should Arise Out Of and Connect to Indigenous Knowledge Bases and Should Foster Choice

In Alaska there has been an important intellectual and cultural movement among Alaska Natives to revive and reclaim their culture and past, and to base programs, interventions, and processes of change on indigenous ways of knowing. In order to accomplish this connection, any prevention program must identify the elders and local experts who are the keepers of wisdom and see them as resources in the articulation of a knowledge base that allows the intervention to proceed in a culturally consistent way:

Native communities have their own standards by which they define the problems associated with the consumption of alcohol. If interventions are made, or alcohol studies undertaken, then they have to account for the Native cultural perspective. (Hild, 1987, p. 85)

So too, Native cultures have their own conceptualizations of health and disease as well as means of prevention and healing. At times, Western and Native traditions and approaches can be synthesized. Other times, they may operate in a parallel fashion. However, when program developers or workers fail to recognize potential cultural differences in the way in which personal choice is understood, they risk intervening in ways that lead to resistance rather than commitment. Each of the innovations described above fostered personal and community choice. The sense in Alaska is that program interventions must arise out of an analysis of what makes sense to the particular Native community and what fits their history and their cultural view of health and illness. The interventions describe in this chapter follow these principles and maximize community potential.

Western Knowledge Can Be a Critical Element If It Is Contextualized Within a Culturally and Community Relevant Framework

Programs need to articulate local knowledge and create bridges to Western knowledge. A rural leader once told us that she wanted to have experts in suicide come to the village rather than just be asked to figure out the solutions and have a facilitator present. She said, "What do they think? If we knew what to do we would have done it and prevented this from happening in the first place. Sometimes we don't know and we need expertise we don't have." There exist numerous examples of how Western knowledge has been critical in eradicating disease (e.g., tuberculosis treatment and childhood vaccinations). However, even these projects need to think through the diverse cultural orientations and devise ways in which collaboration and community choice can be maximized. Behavioral health and alcohol programs must think through these same issues as we try to use Western knowledge so that it can help communities to eradicate the persistent problems confronted by rural villages.

Training and Prevention Must Foster Connectivity

From the descriptions of the innovations described, the reader can discern that training of local people is critical to prevention

work. What is so important about the Rural Human Services Certificate program is how it is done, not simply that it targets local people. The program is successful because it blends teaching of content in both Western and indigenous knowledge bases with personal development. While attending a meeting of the supervisors of rural human services workers, we were struck by the statement of one of the supervisors that community members wanted to attend the training program because they saw the impact it had on the personal development of their prevention or mental health workers. Clearly, personal development and the acquisition of knowledge and skills are integrated in this program, not separated as they are in most university education. Training programs must not separate and automatize knowledge in skill domains and independent groupings, but must provide a framework for integrating a person's development emotionally, cognitively, socially, and culturally. Education becomes a process of transformation. An indigenous model of education is operative both in process and content.

Prevention Efforts Must be Embedded Within an Empowerment Paradigm

A fundamental principle of all health promotion programs described in this chapter is that prevention work in villages should foster community ownership, self-reliance, and empowerment. Therefore, it should not be surprising when carving clubs, dance groups for youth, and traditional camps, developed by local people and communities and intended to increase the sense of competence and efficacy of the population, also aim to lower the risk and rates of behavioral health and alcohol and drug abuse problems. Organizing a dance group involves recruitment and participation of elders, negotiations about beliefs and religion, and involvement of the community in providing a place. Separate domains do not exist in the same way in a small rural village as they do in urban areas where services are provided by specialized professionals. However, villages do have institutional frameworks as well as informal turf, so that connectivity demands carefully building consensus among multiple groups.

Perhaps the most important lesson from the local option laws is that communities make a statement of what they want for the quality of life in their village. Consequently, the community does set limits to personal choice, which exist in the context of communally established values and limits. The policy dimensions of alcohol taxation and forms of prohibition relate to the importance of community choice and responsibility. Thus, evaluations of the effectiveness of these policies must not be based simply on short-term outcomes as measured by volume of alcohol bought and consumed, but on the longer-term process of the community setting and enforcing standards of behavior.

The work of prevention should become a synergistic process that creates new community resources and ways for village people to work together with each other, with agencies, and with Western professionals: a process of building and multiplying local resources and capacities. Such a model and process of prevention rejects a scarcity paradigm that depends on highly specialized and professionalized expertise and interventions, and in contrast, uses a community empowerment paradigm. Community empowerment encourages local self-care, builds local understanding and access to both Western and indigenous knowledge bases and methods, and leads to innovative village-based programs for prevention and health promotion.

Finally, in Alaska and the United States we seem at this point in history to embrace a strong belief in less government, more individualism, and less use of government funding. However, many enduring social and health problems take much more than exhortation. They take time, effort, careful planning and research, attention to supporting those doing the work, evaluation, and large amounts of time and energy from diverse individuals who possess relevant expertise. This takes adequate and consistent financial support. The current ideology that less funding for research and intervention will lead to better services is naive and significantly limits the building of prevention.

Acknowledgments

We would like to thank those who reviewed the manuscript and provided insightful comments. We would further like to acknowledge and honor the hard work and dedication of people and their innovative projects that provided substance for this paper: Robert Charlie and the elders, youth, and staff of the Old Minto Cultural Heritage Camp; Howard Luke and the Ga'alleya Spirit Camp; the Alaska Federation of Natives Sobriety Movement; the organizers and participants of the Alaska Alcohol and Drug Abuse Prevention Symposium and the Rural Providers Conference; the faculty, staff, and students of the Rural Human Services Certificate Program of the University of Alaska Fairbanks; the staff and communities of The Road Back: A Village-Based Prevention Strategy and the Alaska Siberia Medical Research Program; the staff and service providers of the Alaska Native Health Board, Alaska Health Fair, Inc., Interior AIDS Association, Maniilaq Health Corporation, and the State of Alaska Community-Based Suicide Prevention Program, and all the other dedicated people working to prevent health and behavioral health problems in Alaska.

Endnote

1. Charleen Fisher, The Road Back Project Director and Evaluation Coordinator, is the author of this section. She also edited the section on the ethnographic case study from a Council of Athabaskan Tribal Governments document written by Alicia Martinez, Ph.D., proposing a model for this study. We appreciate Ms. Fisher's contribution to this chapter.

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